

CONTENT	PAGE
<p>Overview</p> <ul style="list-style-type: none"> - Descriptive summary of station - Main assessment aims - Station coverage - Station requirements 	2-3
Instructions to Candidate	4
Station Operation Summary	5
<p>Instructions to Examiner</p> <ul style="list-style-type: none"> - Your role - Background information for examiners - The Standard Required 	<p>6</p> <p>6-12</p> <p>13</p>
Instructions to Role Player	14-16
Marking Domains	17-19

1.0 Descriptive summary of station:

Fern Woods is a 58-year-old woman who has a serious hoarding disorder, predominantly of paper. This has been exacerbated by her relationship breakdown. The police have been involved due to multiple complaints from neighbours. Despite Fern's severe hoarding disorder, she continues to work full-time in a position of high responsibility. The candidate is expected to take a history of the presenting complaint, formulate the presentation, make the diagnosis of hoarding disorder, giving possible differential diagnoses, and make a considered comment on the risk issues.

1.1 The main assessment aims are to:

- Evaluate the clinical presentation and formulate a diagnosis of hoarding disorder.
- Demonstrate awareness of the risks and management of these risks.
- Show compassion for Fern's predicament.

1.2 The candidate should be able to demonstrate the following to achieve the required standard:

- Explore for symptoms of both depression and obsessive-compulsive disorder.
- Maintain a compassionate approach to Fern's predicament.
- Link the worsening of her disorder to the breakdown of her marriage.
- Justify a diagnosis of hoarding disorder or OCD – hoarding type according to diagnostic criteria.
- Identify fire risk, at least one other risk to self, and at least one risk to others.

1.3 Station covers the:

- **RANZCP OSCE Curriculum Blueprint Primary Descriptor Category:** Other Disorders, Anxiety Disorders
- **Area of Practice:** Adult Psychiatry
- **CanMEDS Marking Domains Covered:** Medical Expert, Professional
- **RANZCP 2012 Fellowship Program Learning Outcomes:** Medical Expert (Assessment – Data Gathering Content, Formulation, Diagnosis, Management – Initial Plan); Professional (Integrity, Honesty, Compassion, Respect)

References:

- Diagnostic and Statistical Manual of Mental Disorders DSM-5 (2013) American Psychiatric Association. Available at: <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm06> (accessed 18 October 2019)
- 2020 ICD-10-CM Codes (2018) Free Reference Website. International Classification of Diseases. Available at: <https://www.icd10data.com/ICD10CM/Codes/F01-F99/F40-F48/F42-/F42.3> (accessed 18 October 2019)
- International OCD Foundation (IOCDF) – Diagnosing Hoarding Disorder. Available at: <https://hoarding.iocdf.org/professionals/clinical-assessment/> (accessed 18 October 2019)
- International OCD Foundation (IOCDF) – Clinical Assessment. Available at: <https://hoarding.iocdf.org/professionals/clinical-assessment/> (accessed 18 October 2019)
- International OCD Foundation (IOCDF) – Treatment. Available at: <https://hoarding.iocdf.org/professionals/treatment-of-hoarding-disorder/treatment-of-hd-medication/> (accessed 18 October 2019)
- Frost RO, Tolin DF, Steketee G, Fitch KE, Selbo-Bruns A (2009) Excessive acquisition in hoarding. *Journal of Anxiety Disorders* 23(5):632–639. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2735347/> (accessed 18 October 2019)
- Frost RO, Steketee G, Tolin DF (2011) Comorbidity in hoarding disorder. *Journal of Depression and Anxiety* 28(10):876–884, 2011b. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3188689/> (accessed 18 October 2019)

Committee for Examinations
Objective Structured Clinical Examination
Station 1
OSCE July 2021



- Table 2 Comorbid disorders in OCD in: Reddy YCJ, Sundar AS, Narayanaswamy JC, Math SB (2017) Clinical practice guidelines for Obsessive-Compulsive Disorder. *Indian Journal of Psychiatry* v.59 (Suppl 1); 2017 Jan. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5310107/> (accessed 26 May 2020)
- Image of paper hoarding: Available at: <https://vivblogs.com/2013/02/28/paper-hoarder-2170-2197/> (accessed 26 May 2020)
- Alexopoulos GS, Meyers BS, Young RC, Campbell S, Silbersweig D, Charlson M. 'Vascular depression' hypothesis. *Archives of General Psychiatry*, 1997; 54(10), 915-922

1.4 Station requirements:

- Standard consulting room; no physical examination facilities required.
- Five chairs (examiners x 2, role player x 1, candidate x 1, observer x 1).
- Laminated copy of 'Instructions to Candidate'.
- Role player: female in her 50s or 60s, neatly but casually dressed.

2.0 Instructions to Candidate

You have **fifteen (15) minutes** to complete this station after **five (5) minutes** of reading time.

You are working as a junior consultant psychiatrist in an acute adult mental health service. You have been asked to see Fern Woods, a 58-year-old woman, who was brought into the emergency department today by the community acute mental health team.

Mrs Woods' neighbours had reported to the police that they thought her house was a hazard. Additionally, there were rats and mice coming into their property which they believe came from Mrs Woods' house.

When the police did a welfare check they noticed the extent of the problem and so called the community acute mental health team to do an assessment. The clinicians assessing her were concerned about Mrs Woods and about the state of her home. They photographed her property, and one picture has been brought to show you.

Mrs Woods is distressed and embarrassed to be at the hospital. She is the deputy principal of the local high school and is upset that people may have noticed a police car parked outside her premises, and that the neighbours have reported her to the police despite her reassuring them that she had the situation under control.

She has no family locally and has not had contact with mental health services in the past.

Your tasks are to:

- Take a focussed history from Mrs Woods.
- Present the following **to the examiners**:
 1. A formulation based on the information you have obtained
 2. The diagnosis and differential diagnoses you would consider
 3. A risk assessment and a plan for managing these risks in the immediate future.

PHOTO OF FERN WOODS' LIVING ROOM



Station 1 - Operation Summary

Prior to examination:

- Check the arrangement of the room, including seating and other specifics to your scenario.
- On the desk, in clear view of the candidate, place:
 - A copy of 'Instructions to Candidate' and any other candidate material specific to the station.
 - Water and tissues (available for candidate use).
- Do a final rehearsal with your simulated patient and co-examiner.

During examination:

- Please ensure mark sheets and other station information, are out of candidate's view.
- At the **first bell**, take your places.
- At the **second bell**, start your timer, check candidate ID number and photo on entry.
- TAKE NOTE there are no cues or time prompts for you to give.
- DO NOT redirect or prompt the candidate unless scripted – the simulated patient has prompts to use to keep to the aims.
- If the candidate asks you for information or clarification say:
'Your information is in front of you – you are to do the best you can.'
- At **fifteen (15) minutes**, as indicated by the timer, the final bell will ring. Finish the examination immediately.

▪ At conclusion of examination:

- Retrieve all station material from the candidate.
- Complete marking, and place your mark sheet in an envelope by/under the door for collection (**do not seal envelope**).
- Ensure room is set up again for next candidate. (See 'Prior to examination' above.)

If a candidate elects to finish early after the final task:

- You are to state the following:

'Are you satisfied you have completed the task(s)?

If so, you must remain in the room and NOT proceed to the next station until the bell rings.'

- If the candidate asks if you think they should finish or have done enough etc., refer them back to their instructions and ask them to decide whether they believe they have completed the task(s).

3.0 Instructions to Examiner

3.1 In this station, your role is to:

Observe the activity undertaken in the station, and judge it according to the station assessment aims and defined tasks as outlined in 1.1 and 1.2.

When the candidate enters the station, briefly check the candidate ID number and photo.

The role player opens with the following statement:

'Hello Doctor, I am not sure why I am seeing you?'

3.2 Background information for examiners

In this station, the candidate is expected to interview Mrs Fern Woods who is a 58-year-old woman with a serious hoarding disorder, primarily of paper, which has been exacerbated by her relationship breakdown. The police have been involved due to multiple complaints from neighbours. Despite Fern's severe hoarding, she continues to work full-time in a position of high responsibility.

The candidate is expected to take a history of the presenting complaint, make sense of it in a formulation, provide their diagnosis and possible differential diagnoses. They are expected to justify a diagnosis of hoarding disorder or OCD – hoarding type based on 1) inability to discard, 2) distress when trying to discard things, and 3) impact on her life. The candidate should be able to provide a concise presentation of the diagnosis with a reasonable differential diagnosis of depression exacerbating the hoarding. They may exclude OCD, other anxiety disorders, psychosis and substance use disorders. A comorbid depressive illness may be a part of the principal diagnosis.

The candidate should then make a considered comment on the risk issues and specifically focus on the risks related to the photo of Fern's lounge room. They should demonstrate some understanding of the various risks related to paper hoarding and how it could result in a cluttered home environment; can lead to falls and injury to self or visitors; unsanitary conditions leading to pest infestations posing risk to health; legal health code violations; fire risk; family strain; conflict and social isolation; significant risk to neighbours; and cost to community, even death.

Finally, the candidate is expected to outline options for the immediate management of these risks.

The candidate should be able to demonstrate the following to achieve the required standard:

- Explore for symptoms of both depression and obsessive-compulsive disorder.
- Maintain a compassionate approach to Fern's predicament.
- Link the worsening of her disorder to the breakdown of her marriage.
- Justify a diagnosis of hoarding disorder or OCD – hoarding type according to diagnostic criteria.
- Identify fire risk and at least one other risk to self and one risk to others.

A surpassing candidate may:

- demonstrate some understanding of the biological, psychological and social aspects that underpin the development and progression of hoarding behaviour.
- Articulate a sophisticated understanding of the various risks related to paper hoarding.

Background

A recent review commissioned by the DSM-5 Anxiety, Obsessive-Compulsive Spectrum, Post-Traumatic, and Dissociative Disorders Work Group recommended the addition of hoarding disorder as a separate diagnostic entity. In DSM-5 hoarding is not considered to be a subtype of OCD but a distinct condition related to a variety of disorders including OCD. Either a diagnosis of hoarding disorder or OCD – hoarding type are acceptable.

The principal characteristics of hoarding are excessive acquisition of possessions and difficulty discarding possessions. The resultant effect of excessive acquisition and inability to discard is severely cluttered living spaces. The significant clutter obstructs the person's home environment causing functional impairment including substantial health risk, impairment, violation of health codes, risk of eviction, fire, family conflict and burden, cost to community, and even death.

Thus, excessive acquisition of possessions can lead to compulsive hoarding, with inability to discard excessive possessions. The action of acquisition involves buying of unwanted items or failure to dispose of items (e.g. newspapers, 'junk' mail, empty food containers), free things (e.g. free brochures, giveaways and discarded items). These items accumulate in the home due to difficulty discarding. For some people their indecisiveness about their possessions causes clutter to accumulate gradually over time.

In respect of the underlying determinants of hoarding, the high comorbidity of mood and/or anxiety disorder may indicate an etiological basis. The relationship between hoarding disorder and anxiety/depression remains unclear: does the significant burden and impairment produced by hoarding behaviour cause the comorbidity of depression and anxiety or does depression and anxiety predispose to hoarding in specific circumstances, temperaments and personalities?

There is also association in some individuals with inattentive attention deficit hyperactivity disorder (ADHD). Attention problems may be a determinant of hoarding because of deficits in information processing. It has been found that obsessive compulsive personality disorder (OCPD) is more frequent in hoarding disorder (HD) than OCD. Most likely comorbid illnesses associated with hoarding are major depressive disorder (MDD), OCD, generalised anxiety disorder (GAD) or social phobia.

Hoarding is often resistant to treatment.

Clinical assessment

There are several standard rating scales to assist in the diagnosis of hoarding disorder as per the DSM-5 definition and to assess the severity and impact of hoarding disorder on the person.

Saving Inventory – Revised (SI-R)

The Saving Inventory – Revised is a 23-item questionnaire designed to measure three features of hoarding disorder: excessive acquisition, difficulty discarding and clutter. Scoring instructions are located at the end of the questionnaire, along with a table showing the average scores of people who do not suffer from hoarding disorder, as well as cut-off scores that typically indicate a significant clinical hoarding problem and/or hoarding disorder diagnosis.

Hoarding Rating Scale (HRS)

The Hoarding Rating Scale is a brief 5-item scale that can be given as a semi-structured clinician interview or as a questionnaire. This tool includes 5 questions about clutter, difficulty discarding, excessive acquisition, and the resulting distress and impairment caused by hoarding. Initial studies suggest that a score of 14 or higher on the HRS indicates a probable hoarding problem/hoarding disorder diagnosis.

Clutter Image Rating (CIR)

The Clutter Image Rating is a tool that helps standardise definitions of clutter by showing a series of images depicting rooms in various stages of clutter. This allows the client, the clinician or another observer to select the image on the scale that best corresponds with the state of the main rooms in the home. The CIR contains three sets of 9 pictures to clarify the level of clutter in the kitchen, the living room and the bedroom. The living room photos can be used to rate other types of rooms in the home. In general, rooms that are rated as picture #4 or higher indicate a probable hoarding problem/hoarding disorder diagnosis.

DIAGNOSIS:

Hoarding as a specific entity has only recently been accepted as an independent diagnosis in the DSM-5 (2013) and has recently been included in the new ICD-10-CM (2020).

2020 ICD-10-CM Diagnosis Code F42.3: Hoarding disorder

The original International Classification of Diseases (ICD) did not list hoarding disorder separately in ICD-10. On 1 October 2017 the World Health Organisation added hoarding disorder as a new category under obsessive-compulsive disorder (Code: 42.3).

Codes: F42.Obsessive-compulsive disorder

- F42.2 Mixed obsessional thoughts and acts
- F42.3 Hoarding disorder
- F42.4 Excoriation (skin-picking) disorder
- F42.8 Other obsessive-compulsive disorder
- F42.9 Obsessive-compulsive disorder, unspecified

Obsessive-compulsive and related disorders in DSM-5

Obsessive-compulsive and related disorders include OCD, body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder, substance/medication-induced obsessive-compulsive and related disorder, obsessive-compulsive and related disorder due to another medical condition and other specified obsessive-compulsive and related disorder and unspecified obsessive-compulsive and related disorder (e.g. body-focussed repetitive behaviour disorder, obsessional jealousy).

Hoarding disorder is characterised by persistent difficulty discarding or parting with possessions, regardless of their actual value, as a result of a strong perceived need to save the items and to distress associated with discarding them. Hoarding disorder differs from normal collecting. For example, symptoms of hoarding disorder result in the accumulation of many possessions that congest and clutter active living areas to the extent that their intended use is substantially compromised. The excessive acquisition form of hoarding disorder, which characterises most but not all individuals with hoarding disorder, consists of excessive collecting, buying, or stealing of items that are not needed or for which there is no available space.

DSM-5 Hoarding disorder

Hoarding disorder diagnostic criteria 300.3

- A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.
- B. This difficulty is due to a perceived need to save the items and to distress associated with discarding them.
- C. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g. family members, cleaners, authorities).
- D. The hoarding causes clinically significant distress or impairment in social, occupational or other important areas of functioning (including maintaining a safe environment for self and others).
- E. The hoarding is not attributable to another medical condition (e.g. brain injury, cerebrovascular disease, Prader-Willi syndrome).
- F. The hoarding is not better explained by the symptoms of another mental disorder (e.g. obsessions in OCD, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder, cognitive deficits in major neurocognitive disorder, restricted interests in autism spectrum disorder).

Specify if:

With excessive acquisition: If difficulty discarding possessions is accompanied by excessive acquisition of items that are not needed or for which there is no available space.

Specify if:

With good or fair insight: The individual recognises that hoarding-related beliefs and behaviours (pertaining to difficulty discarding items, clutter, or excessive acquisition) are problematic.

With poor insight: The individual is mostly convinced that hoarding-related beliefs and behaviours (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.

With absent insight/delusional beliefs: The individual is completely convinced that hoarding-related beliefs and behaviours (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.

Differential diagnoses to consider:

- Obsessive-compulsive personality disorder – enduring and pervasive pattern of excessive preoccupation with perfectionism, orderliness and rigid control; rigidity, stubbornness, no obsessions or compulsions.
- Depression – depressive ruminations usually ego-syntonic associated with self-criticism, failure, regret, guilt, pessimism without compulsions.
- Generalised anxiety disorder – anxious ruminations about real-life concerns without compulsions.
- OCD – other types of obsessions and compulsions.
- Psychotic disorder – delusions of persecution, grandiose themes with other symptoms like thought disorder and hallucinations help differentiate the two conditions. There is no delusional basis for her not throwing things away.
- Substance use disorder leading to neglect of her home. However, she functions well in other settings and there is no neglect of self. She denies substance use.

Discussion of diagnosis

With respect to excessive acquisition: Approximately 80–90% of individuals with hoarding disorder display excessive acquisition. The most frequent form of acquisition is excessive buying, followed by acquisition of free items (e.g., leaflets, items discarded by others; Frost et al., 2009). Individuals with hoarding disorder typically experience distress if they are unable to, or are prevented from, acquiring items.

The essential feature of hoarding disorder is persistent difficulties discarding or parting with possessions, regardless of their actual value (Criterion A). The 'persistent' indicates a long-standing difficulty rather than transient life circumstances that lead to excessive clutter. The difficulty in discarding possessions refers to any form of discarding, including throwing away, selling, giving away or recycling. The main reasons given are the perceived utility or aesthetic value of the items or strong sentimental attachment to the possessions. Some feel responsible for the fate of their possessions and often go to great lengths to avoid being wasteful. Fears of losing important information are also common. The most commonly saved items are newspapers, magazines, old clothing, bags, books, mail and paperwork, but virtually any item can be saved. The nature of items is not limited to possessions that most other people would define as useless or of limited value. Many individuals collect and save large numbers of valuable things as well which are often found in piles mixed with other less valuable items.

Individuals with hoarding disorder purposefully save possessions and experience distress when facing the prospect of discarding them (Criterion B). The emphasis is the saving of possessions is intentional which discriminates hoarding disorder from other forms of psychopathology that are characterised by the passive accumulation of items or the absence of distress when possessions are removed.

Individuals accumulate large numbers of items that fill up and clutter active living areas to the extent that their intended use is no longer possible (Criterion C). The individual may not be able to cook in the kitchen, sleep in their bed or sit in a chair. If the space can be used, it is only with great difficulty. Clutter is defined as a large group of usually unrelated or marginally related objects piled together in a disorganised fashion in spaces designed for other purposes (e.g. tabletops, floor, hallway; Steketee and Frost, 2003). Criterion C emphasises the 'active' living areas of the home, rather than more peripheral areas, such as garages, attics, or basements that are sometimes cluttered in homes of individuals without hoarding disorder. However, individuals with hoarding disorder often have possessions that spill beyond the active living areas and can occupy and impair the use of other spaces, such as vehicles, yards, the workplace and friends' and relatives' houses. In some cases, living areas may be uncluttered because of the intervention of third parties (e.g. family members, cleaners, local authorities). Individuals who have been forced to clear their homes still have a symptom picture that meets criteria for hoarding disorder because the lack of clutter is due to a third-party intervention. Hoarding disorder contrasts with normative collecting behaviour, which is organised and systematic; normative collecting does not produce the clutter, distress or impairment.

Symptoms (difficulties discarding and/or clutter) cause clinically significant distress or impairment in social, occupational or other important areas of functioning, including maintaining a safe environment for self and others (Criterion D). In some cases, particularly when there is poor insight, the individual may not report distress and the impairment may be apparent only to those around the individual. However, any attempts to discard or clear the possessions by third parties result in high levels of distress.

Associated features supporting diagnosis

Other common features include indecisiveness, perfectionism, avoidance, procrastination, difficulty planning and organising tasks and distractibility. Some individuals with hoarding disorder live in unsanitary conditions that may be a logical consequence of severely cluttered spaces and/or that are related to planning and organising difficulties.

Development and course

- Hoarding appears to begin early in life and spans well into the late stages.
- Hoarding symptoms may first emerge around ages 11–15 years, start interfering with the individual's everyday functioning by the mid-20s and cause clinically significant impairment by the mid-30s.
- The severity of hoarding increases with each decade of life.
- Once symptoms begin the course of hoarding is chronic; few individuals report a waxing and waning course.

Risk and prognostic factors

Temperamental – Indecisiveness in the hoarder and their first-degree relatives.

Environmental

May retrospectively report stressful, traumatic life events preceding onset or causing exacerbation.

Genetic and physiological

Hoarding behaviour is familial with about 50% of individuals who hoard having a relative who also hoards.

Functional consequences of hoarding disorder

- Clutter impairs basic activities, like moving through house, cooking, cleaning, personal hygiene, sleeping.
- Appliances may be broken and utilities such as water and electricity may be disconnected as access for repair work may be difficult.
- Impair quality of life.
- In severe cases, hoarding increases risk of fire, falls, poor sanitation, etc.
- Increase occupational impairment, poor physical health and high social service utilisation.
- Family relationships are frequently under great strain.
- Conflict with neighbours and local authorities is common, involved in legal eviction proceedings or eviction.

Dangers to health from hoarding

- Include mould growth, bug infestations, structural damage and tripping hazards.
- Hoarding can overwhelm the mind, cause stress, anxiety and drain energy levels.
- Bug infestations and bites can be dangerous such as mosquitos, ticks, bacteria, cockroaches.
- Rodent infestations with mice and rats bring bacteria, diseases and viruses.
- Human or animal faeces and urine can spread bacteria.
- Tripping hazards.
- Emergency workers can be injured trying to help the hoarder in lifesaving emergencies.
- Clutter piles can fall, block paths around the house, block airflow so low levels of oxygen or cool air.
- Clutter can fall on vents or block other airways, causing a lack of oxygen and raising carbon dioxide levels.
- Heavier clutter can fall on the hoarder and potentially injure them or trap them under the pile of clutter.
- There may be water damage weakening the structure.

Paper hoarding

Paper products often hoarded include books, newspapers, journals and other paper products. When these paper products begin to pile up, it can make an individual's living environment unsafe.

Dangers of paper hoarding

Collapsing paper piles

- In extreme cases paper piles can grow as high as the height of the ceiling.
- High paper piles mean the hoarder may try to develop pathways through the paper products.
- High paper piles can be extremely unstable with risk of paper piles collapsing on the hoarder. It may result in entrapment and the hoarder may be crushed under the weight.

Pests in paper

- Pests can become a significant problem.
- Pests include bugs and/or rodents that make their homes in the piles of paper.
- Pests can bring various diseases that can cause health issues for the hoarder.
- The hoarder is at risk of injuries due to potential bites from bugs and vermin.
- Neighbours can be affected by pests that leave the home to forage for food, causing the community to notice the hoarder's lack of cleanliness and maintenance within their home.

Home repair problems

- Neglect of many home systems necessary for a healthy living environment.
- Paper can fill entire rooms and make them unusable for their intended purpose e.g. bathrooms, kitchens, lounges, bedrooms, hallways, doors.
- Paper piles can also block critical components of the home, such as the home's heating system.

Paper fire hoarding dangers

- Fire is a concern in a paper hoarding.
- Paper can block critical access points to the home's heating and electrical systems. Without access to these systems, the level of fire safety in the property may be low due to the lack of maintenance.
- Paper is highly flammable.

Gold standard, evidence-based treatments for hoarding disorder are still being researched and developed. Often clinicians achieve the most benefit from using a combination of psychological and pharmacological treatment.

Formulation

Formulation is a formal requirement in the RANZCP 2012 Fellowship Program in the presentation of the Observed Clinical Activity (OCA). OCA Formulation Guidelines can be found on the College website and registrars will have completed multiple OCAs during their training. As such, candidates are expected to be practised and well prepared to present a sophisticated formulation of the current case.

According to the RANZCP OCA guidelines, "formulation is a set of explanatory hypotheses (or speculations), which address the question:

'Why does **this patient** suffer from **this problem** at **this point** in time?'

The formulation is an integrated synthesis of the data. It should demonstrate an understanding of this unique individual, with the patient's vulnerabilities and resources and how the patient comes to be in the current predicament.

The essential task in formulation is to highlight possible linkages or connections between different aspects of the case. The focus upon these inter-relationships adds something new to what has already been presented. In this sense, the formulation is more than a summary". It is a synthesis.

In the biopsychosocial formulation, the candidate provides their understanding of how the predisposing, precipitating, perpetuating and protective factors interact to explain the predicament of the patient.

There is no universally accepted format or framework for presenting formulations. The candidate may consider a number of perspectives based on a hypothetic-deductive model. Reasonable hypotheses that could potentially explain the current psychiatric presentation should be offered and such hypotheses might be tested in further enquiries in a deductive manner. The College guidelines suggest that a variety of models or frameworks may be used in preparing a formulation.

In the current scenario, candidates might choose to highlight some of the following aspects:

Biological aspects might include:

- Fern has a reported family history of hoarding disorder which may represent a genetic predisposition to suffering this condition.
- She recently has experienced a low mood and weight loss after her marriage break up.

- She is 58 years old which may place her at risk of a range of medical disorders presenting with depression including vascular depression (Alexopoulos et al., 1997) or early vascular dementia.

Psychological, developmental and social aspects might include:

- Fern's dedication to work success and desire to prevent anyone from knowing about her hoarding disorder put her at risk of experiencing shame and increases her risk for depression.
- In her family, hoarding was normalised by the fact that three generations of family members before her never seemed to throw things away, and collected sheds full of objects that now are the bearers of memories and stories of her family's past.
- Her loss of her husband through divorce, family due to their wanting to avoid her, and friends due to her inability to entertain in her home have led to worsening social isolation and loss of her support network.
- Her husband would also attempt to limit her hoarding by ensuring that parts of the home were habitable, limiting the space available to accumulate things.
- The distress associated with discarding her possessions makes it harder for her to dispose of her unwanted possessions.

There are some protective factors, however. Fern has no past psychiatric illness and no substance use history. There is no evidence of obsessions or compulsions. Her work history and professional success are other potential positive factors that might promote resilience.

The RANZCP Guidelines suggest a formulation comprising three sections.

Section I – Presentation and context

This will usually be a brief introductory statement that places the patient's predicament in context. In this case, an example might be: *'Fern is a 58-year-old divorced woman who is the deputy principal of the local high school who lives alone, who was brought in by the local mental health team following complaints from her neighbours of her failure to care for her property.'*

Section II – Focussed history with potential explanatory power

This section highlights the candidates' sense of emphasis and priority in presenting the most important aspects of the history. The biological, psychological and socio-cultural aspects listed above might well be presented here. One might expect to hear a detailed account of the series of interpersonal losses Fern has suffered over the past three years, as well as the ongoing stress related to her inability to discard unwanted possessions. Some attempt to identify aspects of Fern's premorbid personality and her past coping strategies would be usefully presented here.

Section III – Linkages using theoretical framework

Here the RANZCP Guidelines note that 'the task of this section is to make linkages between the material of Section I and II using hypotheses derived from an acceptable model or framework. Thus, the patient's vulnerabilities are juxtaposed with current stressors to provide a plausible explanatory statement. Given the candidate's limited knowledge of the patient, the formulation will invariably be hypothetical. In other words, it would usually involve a set of 'educated guesses'. It is the plausibility of these speculations which makes the difference between a good and a poor formulation.

In the present case, one would expect the candidate at a junior consultant level to provide some theoretical framework within which to speculate on the meaning, impact and/or personal salience of the losses Fern has suffered. Such a framework might include concepts such as: loss sensitivity; attachment style; pathological grief; personality traits and coping mechanisms; relative lack of social support; feelings of estrangement; limited coping strategies or maladaptive defences; concepts of temperament and character; concepts from psychodynamic theories of depression or any other of a wide range of possibly relevant theories.

3.3 The Standard Required

Surpasses the Standard – the candidate demonstrates competence above the level of a junior consultant psychiatrist in several of the domains described below.

Achieves the Standard – the candidate demonstrates competence expected of a junior consultant psychiatrist. That is the candidate is able to demonstrate, *taking their performance in the examination overall*, that

- i. they have competence as a **medical expert** who can apply psychiatric knowledge including medicolegal expertise, clinical skills and professional attitudes in the care of patients (such attitudes may include an ability to tolerate uncertainty, balance, open-mindedness, curiosity, 'common sense' and a scientific approach).
- ii. they can act as a **communicator** who effectively facilitates the doctor–patient relationship.
- iii. they can **collaborate** effectively within a healthcare team to optimise patient care.
- iv. they can act as **managers** in healthcare organisations who contribute to the effectiveness of the healthcare system, organise sustainable practices and make decisions about allocating resources.
- v. they can act as **health advocates** to advance the health and wellbeing of individual patients, communities and populations.
- vi. they can act as **scholars** who demonstrate a life-long commitment to learning as well as the creation, dissemination, application and translation of medical knowledge.
- vii. they can act as **professionals** who are committed to ethical practice and high personal standards of behaviour.

Below the Standard – the candidate demonstrates significant defects in several of the domains listed above.

Domain Not Addressed – the candidate demonstrates significant defects in all of the domains listed above or the candidate demonstrates significant defects in the first domain of being a medical expert.

4.0 Instructions to the Role Player

4.1 This is the information you need to memorise for your role:

You are Fern Woods, a 58-year-old Anglo-Australian/New Zealand woman. You are an English teacher by training and work as a deputy principal at the local high school for the past 15 years. You live alone in a free-standing home near the hospital.

The present situation

You are meeting the doctor today because the police came to your home this morning to do a welfare check. They noticed how you were living and were very concerned. They arranged for you to be seen by the mental health team who then brought you here. You find the entire process humiliating. Your neighbours would have seen a police car outside your home and wondered what was happening.

The police told you they were responding to multiple complaints from neighbours that your house is a fire hazard, especially as it has been hot lately, and your grass is very long and dry. The neighbours say that the conditions in your house are the cause of the escalation in rats and mice coming into their property. The mental health team took photos inside your house and have given a photo of your lounge to the doctor. It is embarrassing because it shows how much paper, books and magazines and other things you have lost track of that are in your lounge.

Your hoarding history

You know you should throw things away. You just can't seem to throw things away once they come into the house. Even the free stuff that comes in the mailbox gets piled in the lounge and wherever you can put it. You have books, newspapers, journals and pamphlets and things from school, like old projects, things from students given to you over the years, and gifts given to you by friends and family over the years too.

You can't really use your lounge room anymore because things are piled up so high that it is tricky to get through without causing some of it to fall. You admit that you have had piles fall on you before, and it was painful. One time you were stuck for a few hours until you could dislodge yourself from the stack that fell on you. You had bruises from it and so called in sick from work for three days until you felt better. You realised something had bitten you too and so tried to spray insecticide, and that made you feel nauseous because you couldn't get across to the windows to open them for more ventilation.

You have accumulated so much stuff especially paper that you can't use them for their intended purpose. You have difficulty letting things go even though it affects how you feel about yourself and the safety of your home. The way you feel leads you to avoid having anyone enter your home. The police coming this morning was very distressing to you.

Your home is an old one with four bedrooms, a long hallway and two bathrooms, a large kitchen, large lounge, dining room and a large laundry with two garages and two large outdoor covered areas. The clutter takes up about 80% of the living space, some of the piles are up near the ceiling, and the paper piles in the lounge are getting too high. You struggle to get around the house and use trails through all your stuff trying not to bump anything. The chairs, tables, couches, and floors are mostly covered with stuff. The rubbish bins are full of stuff you are keeping too.

Your family history

You have lived in the same home all your life. You are the fourth generation to live in your family home. You had a happy childhood with your parents and two older sisters. In the house is the memorabilia of your entire family over generations. You come from what you would describe as a hoarding family – slowly over the generations of your family, belongings were gathered when your great-grandparents and then your grandparents never seemed to throw things away. They would catalogue their things, and now that these generations have passed, you have no clue what to do with all their things. Your maternal grandfather was the '*worst hoarder*'. In the back shed his old machinery and things from the farm are heaped up. Your grandfather put his stuff in there and built another shed for more stuff. It's too scary to go back there. You have photos, clothing and furniture dating back to the 18th century all piled somewhere in the house and in the sheds. Your mum and her siblings have things here too. Even though some of them are deceased, their children do not want their '*old things*' so you still have them. You seem to be the keeper of the memories and stories. But it is becoming increasingly more difficult to keep up with it all.

Decisions about clearing all this stuff have been hard to make because you worry about making the wrong choice. So much of what is in your home does not belong to you and so throwing away things that have belonged to others is just about impossible for you now. Every decision you make comes with a feeling of

loss, and you feel more anxious and distressed by your indecisiveness. Throwing stuff out is a decision, so keeping it means you never deal with the loss of anything because you keep everything.

Your family (sisters and their children) and ex-husband Greg tried to help unclutter your living spaces; tried to clean and organised cleaners. But they have given up trying to help you. Despite all this, you continue to work full-time in a highly responsible position, and there have been no complaints about you at work. You have a wonderful assistant, Pat, who sorts out the papers on your desk and files them away, and destroys things that are not needed. So, no one at work knows that you have this problem.

Personal life

You were married for 17 years to Greg Woods, a local businessman. You thought you were happy together but were aware that he would get frustrated with your inability to throw things away. He did tell you that he would leave if you did not get you act together, but you did not believe him. Then one day he left. The loss of your relationship with your husband has been devastating for you. You miss him so much even though it's been three years since he left you. You do not have any children or pets.

You know that since the breakdown of your marriage to Greg, who was your childhood sweetheart, you have found it increasingly difficult to clear the clutter. You know he left because he could not tolerate the mess. He would try to move things or discard things, but at times you would even become hysterical that he might have thrown something out that you hadn't got to read yet. When Greg left, you tried to get things tidier, but your efforts to gain some control of the mess have been futile. When he lived there, at least the lounge, kitchen and first bathroom were still habitable as he insisted on managing these areas.

You miss him so much and wish he would return. But just last week you heard he had met someone else, and they were dating. This caused you so much distress you have been feeling increasingly down and sad. You have only just been able to go to school, but it is a struggle to maintain your appearance. You couldn't afford to lose your job; it means too much to you.

Until recently your family would visit regularly. They come less and less now because of how you have been living. They try to come in and throw things out or move things or fix things, but it is distressing for you. You have less contact with family because you can't have them come to the house anymore; it's too full, there is no room for you to entertain people or for them to stay. You have managed to keep space in your bedroom, so you can still sleep on the bed and access your belongings.

You have always got on well with people and have a good circle of friends, and before you felt this low you would meet them at cafés or restaurants. You never have friends to your house because of the mess.

You have never used illicit substances and only use alcohol socially.

Other recent symptoms (only if asked specifically):

- You feel slightly lower in mood because of the clutter and are not enjoying socialising as much in the past few months. Sometimes you find yourself crying for no reason. But you still enjoy work.
- You have lost 1–2 kilograms in weight as you don't feel as hungry over the past few months.
- You have less energy, tending to keep to yourself and just coming home.
- Your sleep is fine.
- You have no thoughts about harming yourself or other people.
- You have never seen a psychiatrist or your GP about your emotional problems.
- You have never had a stroke, or head injury, or any other medical problem or never required medication.

You have no reoccurring thoughts, urges, or images that are intrusive, unwanted, and cause you marked anxiety or distress.

You have no strong, usually irresistible impulse to perform an act, especially one that is irrational or contrary to your own wishes (compulsion) in an attempt to try to minimise or remove any unpleasant thoughts, urges, or images. This means you have no compulsions, such as hand washing, counting, ordering, checking or repetitive tasks to minimise or reduce the persistent thoughts or urges.

You have never heard voices, had unusual beliefs that others don't have, unusual experiences or believe you are being watched or followed.

Your memory is very good.

4.2 How to play the role:

Dress professionally and comfortably, and you are well groomed. You have an easy style of interaction but are clearly embarrassed by your living situation, and worried about the impact of this assessment.

Answer the questions as best you can from the information provided.

Do not put in additional information that has not been scripted.

Anything you do not have an answer for say *'Hmmm...'* or *'I don't know...'*

4.3 Opening statement:

'Hello Doctor, I am not sure why I am seeing you.'

4.4 What to expect from the candidate:

The candidate will try to make sense of what you are telling them and will ask a lot of questions. You answer as best you can from the information given to you.

The candidate will then talk to the examiners. When this happens just sit relaxed. The candidate may ask further questions to clarify their understanding of you, and then they will return to talking with the examiners.

4.5 Responses you MUST make:

'I shower at school because I can't get into the bathrooms...there is too much stuff in the way.'

'I'll be the laughing stock of my neighbourhood.'

'I feel so sad and so stupid.'

4.6 Responses you MIGHT make:

If the candidate asks about **medical history**

Scripted Response: *'I am well, I am fine.'*

If the candidate asks about **psychiatric history**

Scripted Response: *'I am well, I'm not mentally unwell.'*

If the candidate asks about **anything you do not have an answer for**

Scripted Response: *'Hmmm...' or 'I don't know...'*

4.7 Medication and dosage that you need to remember:

Nil medication

STATION 1 – MARKING DOMAINS

The main assessment aims are to:

- Evaluate the clinical presentation and formulate a diagnosis of hoarding disorder.
- Demonstrate awareness of the risks and immediate management of these risks.
- Show compassion for Fern’s predicament.

Level of Observed Competence:

1.0 MEDICAL EXPERT

1.1 Did the candidate take an appropriately detailed and focussed hoarding history? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:

demonstrates good understanding of the biological, psychological and social aspects that underpin the development and progression of hoarding behaviour; clearly achieves the overall standard with a superior performance in a range of areas; demonstrates prioritisation and sophistication.

Achieves the Standard (scores 3) by:

demonstrating use of a tailored biopsychosocial approach; conducting a detailed but targeted assessment; obtaining a history relevant to the patient’s problems and circumstances with appropriate depth and breadth; exploring for symptoms of both depression and obsessive-compulsive disorder, focussing on excessive acquisition of and difficulty discarding possessions, resulting in severely cluttered living spaces; demonstrating ability to prioritise; completing a risk assessment relevant to the individual case; clarifying important positive and negative features; assessing for typical and atypical features; exploring possible co-morbid conditions.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered if the candidate includes most or all correct elements.

Below the Standard (scores 2):

has omissions that would detract from the overall quality response; important issues not explored in depth e.g. impact of her condition on her personal relationships.

Below the Standard (scores 1):

if there are significant omissions affecting quality; omissions adversely impact on the obtained content.

Does Not Address the Task of This Domain (scores 0).

1.1. Category: ASSESSMENT – Data Gathering Content	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
Cross (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

7.0 PROFESSIONAL

7.1 Did the candidate demonstrate integrity, honesty, compassion and respect? (Proportionate value - 10%)

Surpasses the Standard (scores 5) if:

sensitively approaches the patient encounter; avoids causing additional distress to her; utilises professional understanding of Fern’s problems effectively to avoid additional humiliation; expertly balances the importance of her professional, community standing against the significant impact of her hoarding on the wider community.

Achieves the Standard (scores 3) by:

attempting to engage in a transparent manner; maintaining a compassionate approach to Fern’s predicament, aiming to balance rights of patient with the rights of others; recognising transference and countertransference, and their impact on providing care; acknowledging the impact of prior history on her decisions and behaviours; working in collaboration with Fern seeking to bring about positive outcomes.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered if the candidate includes most or all correct elements.

Below the Standard (scores 2):

has omissions that would detract from the overall quality response; acknowledges her distress but does not attempt to put her at ease.

Below the Standard (scores 1):

if there are significant concerns about professional interactional style; chooses coercive/manipulative techniques during interactions; treats the patient with disrespect.

Does Not Address the Task of This Domain (scores 0).

7.1. Category: INTEGRITY, HONESTY, COMPASSION, RESPECT	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
Cross (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

1.0 MEDICAL EXPERT

1.8 Did the candidate generate an adequate formulation to make sense of the presentation? (Proportionate value - 25%)

Surpasses the Standard (scores 5) if:

provides a superior performance in a number of areas; demonstrates prioritisation and sophistication; applies a sophisticated sociocultural formulation.

Achieves the Standard (scores 3) by:

identifying and succinctly summarising important aspects of the history, observation and examination; synthesising information using a biopsychosocial framework; integrating medical, developmental, psychological and sociological information; developing hypotheses to make sense of the patient's predicament; accurately describing recognised theories and evidence; commenting on missing or unexpected data; accurately linking formulated elements to any diagnostic statement; including a sociocultural formulation linking the worsening of her disorder to the breakdown of her marriage; analysing vulnerability and resilience factors.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered if the candidate includes most or all correct elements.

Below the Standard (scores 2):

has omissions that would detract from the overall quality response; uses a basic biopsychosocial framework but does not integrate information or hypothesise.

Below the Standard (scores 1):

if there are significant omissions affecting quality; significant deficiencies including inability to synthesise information obtained; failure to question veracity where this is important; provides an inadequate formulation or diagnostic statement.

Does Not Address the Task of This Domain (scores 0).

1.8. Category: FORMULATION	Surpasses Standard		Achieves Standard		Below the Standard		Domain Not Addressed
Cross (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

1.9 Did candidate justify the relevant diagnosis and possible differential diagnosis? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

demonstrates clear awareness that obsessive compulsive disorder and hoarding are not the same entity; appropriately identifies the limitations of diagnostic classification systems to guide treatment.

Achieves the Standard (scores 3) by:

demonstrating capacity to integrate available information in order to formulate a diagnosis and differential diagnoses; demonstrating adequate understanding of diagnostic systems to provide justification for diagnosis of hoarding disorder or OCD – hoarding type according to diagnostic criteria and provides at least 3 differential diagnoses; adequate prioritising of conditions relevant to the obtained history and findings; being aware of the coexistence of depressive symptoms and their significance.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered if the candidate includes most or all correct elements.

Below the Standard (scores 2):

has omissions that would detract from the overall quality response; does not provide a range of differential diagnoses.

Below the Standard (scores 1):

if there are significant omissions affecting quality; inaccurate or inadequate diagnosis; errors or omissions are significant and do materially adversely affect conclusions; does not consider hoarding disorder to be the primary diagnosis.

Does Not Address the Task of This Domain (scores 0).

1.9. Category: DIAGNOSIS	Surpasses Standard		Achieves Standard		Below the Standard		Domain Not Addressed
Cross (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>	

1.11 Did the candidate adequately specify risks and their immediate management? (Proportionate value - 20%)

Surpasses the Standard (scores 5) if:

provides a sophisticated link between the plan and key issues identified; clearly addresses difficulties in the application of the risk management plan.

Achieves the Standard (scores 3) by:

identifying at least 3 risks including to both self and others and specifically includes plan for risk management; considering involuntary/inpatient/community modes; selecting treatment environment; suggesting safe, realistic time frames and a review plan; keeping record and communicating to necessary others; identifying potential barriers; considering the use of professional cleaners/house clearing service; offering option of Fern not returning to the home until it is cleaned; using MHA only if not willing to engage.

A score of 4 may be awarded depending on the depth and breadth of additional factors covered if the candidate includes most or all correct elements.

Below the Standard (scores 2):

has omissions that would detract from the overall quality response; considers inpatient treatment as the main approach to risk management.

Below the Standard (scores 1):

if there are significant omissions affecting quality; omissions will impact adversely on patient care; plan lacks structure or is inaccurate; plan not tailored to patient's immediate needs or circumstances; does not take her wishes into consideration.

Does Not Address the Task of This Domain (scores 0).

1.11. Category: MANAGEMENT – Initial plan	Surpasses Standard	Achieves Standard		Below the Standard		Domain Not Addressed
Cross (X) IN ONE BOX ONLY	5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	0 <input type="checkbox"/>

GLOBAL PROFICIENCY RATING

Did the candidate demonstrate adequate overall knowledge and performance at the level of a junior consultant psychiatrist?

Cross (X) IN ONE BOX ONLY	Clearly Proficient <input type="checkbox"/>	Marginal Performance <input type="checkbox"/>	Not Proficient <input type="checkbox"/>
---------------------------	---	---	---